

(2) *Benefit payments made to participating provider.* When the authorized provider elects to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in §§ 199.4 and 199.5 of this part.

(3) *CEOB.* When a CHAMPUS claim is adjudicated, a CEOB is sent to the beneficiary or sponsor. A copy of the CEOB also is sent to the provider if the claim was submitted on a participating basis. The CEOB form provides, at a minimum, the following information:

- (i) Name and address of beneficiary.
- (ii) Name and address of provider.
- (iii) Services or supplies covered by claim for which CEOB applies.
- (iv) Dates services or supplies provided.
- (v) Amount billed; CHAMPUS-determined allowable charge or cost; and amount of CHAMPUS payment.
- (vi) To whom payment, if any, was made.
- (vii) Reasons for any denial.
- (viii) Recourse available to beneficiary for review of claim decision (refer to § 199.10 of this part).

NOTE: The Director, OCHAMPUS, or a designee, may authorize a CHAMPUS fiscal intermediary to waive a CEOB to protect the privacy of a CHAMPUS beneficiary.

(4) *Benefit under \$1.* If the CHAMPUS benefit is determined to be under \$1, payment is waived.

(i) *Extension of the Active Duty Dependents Dental Plan to areas outside the United States.* The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) may, under the authority of 10 U.S.C. 1076a(h), extend the Active Duty De-

pendents Dental Plan to areas other than those areas specified in paragraph (a)(2)(i) of this section for the eligible beneficiaries of members of the Uniformed Services. In extending the program outside the Continental United States, the ASD(HA), or designee, is authorized to establish program elements, methods of administration and payment rates and procedures to providers that are different from those in effect under this section in the Continental United States to the extent the ASD(HA), or designee, determines necessary for the effective and efficient operation of the plan outside the Continental United States. This includes provisions for preauthorization of care if the needed services are not available in a Uniformed Service overseas dental treatment facility and payment by the Department of certain cost-shares and other portions of a provider's billed charges. Other differences may occur based on limitations in the availability and capabilities of the Uniformed Services overseas dental treatment facility and a particular nation's civilian sector providers in certain areas. Otherwise, rules pertaining to services covered under the plan and quality of care standards for providers shall be comparable to those in effect under this section in the Continental United States and available military guidelines. In addition, all provisions of 10 U.S.C. 1076a shall remain in effect.

(j) *General assignment of benefits not recognized.* CHAMPUS does not recognize any general assignment of CHAMPUS benefits to another person. All CHAMPUS benefits are payable as described in this and other Sections of this part.

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§ 199.8 Double coverage.

(a) *Introduction.* (1) In enacting TRICARE legislation, Congress clearly

has intended that TRICARE be the secondary payer to all health benefit, insurance and third-party payer plans. 10 U.S.C. 1079(j)(1) specifically provides that a benefit may not be paid under a plan (CHAMPUS) covered by this section in the case of a person enrolled in, or covered by, any other insurance, medical service, or health plan, including any plan offered by a third-party payer (as defined in 10 U.S.C. 1095(h)(1)) to the extent that the benefit is also a benefit under the other plan, except in the case of a plan administered under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*).

(2) The provision in paragraph (a)(1) of this section is made applicable specifically to retired members, dependents, and survivors by 10 U.S.C. 1086(g). The underlying intent, in addition to preventing waste of Federal resources, is to ensure that TRICARE beneficiaries receive maximum benefits while ensuring that the combined payments of TRICARE and other health and insurance plans do not exceed the total charges.

(b) *Double coverage plan.* A double coverage plan is one of the following:

(1) *Insurance plan.* An insurance plan is any plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

(2) *Medical service or health plan.* A medical service or health plan is any plan or program of an organized health care group, corporation, or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

(3) *Third-party payer.* A third-party payer means an entity that provides an insurance, medical service, or health

plan by contract or agreement, including an automobile liability insurance or no-fault insurance carrier and a workers' compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies. For purposes of the definition of "third-party payer," an insurance, medical service or health plan includes a preferred provider organization, an insurance plan described as Medicare supplemental insurance, and a personal injury protection plan or medical payments benefit plan for personal injuries resulting from the operation of a motor vehicle.

(4) *Exceptions.* Double coverage plans do not include:

(i) Plans administered under title XIX of the Social Security Act (Medicaid);

(ii) Coverage specifically designed to supplement CHAMPUS benefits (a health insurance policy or other health benefit plan that meets the definition and criteria under supplemental insurance plan as set forth in § 199.2(b));

(iii) Entitlement to receive care from Uniformed Services medical care facilities;

(iv) Certain Federal Government programs, as prescribed by the Director, OCHAMPUS, that are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment of monetary contribution (for example, the Indian Health Service); or

(v) State Victims of Crime Compensation Programs.

(c) *Application of double coverage provisions.* CHAMPUS claims submitted for otherwise covered services or supplies and which involve double coverage shall be adjudicated as follows:

(1) *TRICARE last pay.* For any claim that involves a double coverage plan as defined in paragraph (b) of this section, TRICARE shall be last pay *except* as may be authorized by the Director, TRICARE Management Activity, or a designee, pursuant to paragraph (c)(2) of this section. That is, TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.

(2) *TRICARE advance payment.* The Director, TRICARE Management Activity, or a designee, may authorize payment of a claim in advance of adjudication of the claim by a double coverage plan and recover, under § 199.12, the TRICARE costs of health care incurred on behalf of the covered beneficiary under the following conditions:

(i) The claim is submitted for health care services furnished to a covered beneficiary; and,

(ii) The claim is identified as involving services for which a third-party payer, other than a primary medical insurer, may be liable.

(3) *Primary medical insurer.* For purposes of paragraph (c)(2) of this section, a “primary medical insurer” is an insurance plan, medical service or health plan, or a third-party payer under this section, the primary or sole purpose of which is to provide or pay for health care services, supplies, or equipment. The term “primary medical insurer” does not include automobile liability insurance, no-fault insurance, workers’ compensation program or plan, homeowners insurance, or any other similar third-party payer as may be designated by the Director, TRICARE Management Activity, or a designee, in any policy guidance or instructions issued in implementation of this Part.

(4) *Waiver of benefits.* A CHAMPUS beneficiary may not elect to waive benefits under a double coverage plan and use CHAMPUS. Whenever double coverage exists, the provisions of this Section shall be applied.

(5) *Lack of payment by double coverage plan.* Amounts that have been denied by a double coverage plan simply because a claim was not filed timely or because the beneficiary failed to meet some other requirement of coverage cannot be paid. If a statement from the double coverage plan as to how much that plan would have paid had the claim met the plan’s requirements is provided to the CHAMPUS contractor, the claim can be processed as if the double coverage plan actually paid the amount shown on the statement. If no such statement is received, no payment from CHAMPUS is authorized.

(6) *Lack of payment by double coverage plan.* Amounts that have been denied by a double coverage plan simply be-

cause a claim was not filed timely or because the beneficiary failed to meet some other requirement of coverage cannot be paid. If a statement from the double coverage plan as to how much that plan would have paid had the claim met the plan’s requirements is provided to the CHAMPUS contractor, the claim can be processed as if the double coverage plan actually paid the amount shown on the statement. If no such statement is received, no payment from CHAMPUS is authorized.

(d) *Special considerations—(1) CHAMPUS and Medicare—(i) General rule.* In any case in which a beneficiary eligible for both Medicare and CHAMPUS receives medical or dental care for which payment may be made under Medicare and CHAMPUS, Medicare is always the primary payer. For dependents of active duty members, payment will be determined in accordance to paragraph (c) of this section. For all other beneficiaries eligible for Medicare, the amount payable by CHAMPUS shall be the amount of the actual out-of-pocket costs incurred by the beneficiary for that care over the sum of the amount paid for that care under Medicare and the total of all amounts paid or payable by third party payers other than Medicare.

(ii) *Payment limit.* The total CHAMPUS amount payable for care under paragraph (d)(1)(i) of this section may not exceed the total amount that would be paid under CHAMPUS if payment for that care was made solely under CHAMPUS.

(iii) *Application of general rule.* In applying the general rule under paragraph (d)(1)(i) of this section, the first determination will be whether payment may be made under Medicare. For this purpose, Medicare exclusions, conditions, and limitations will be based for the determination.

(A) For items or services or portions or segments of items or services for which payment may be made under Medicare, the CHAMPUS payment will be the amount of the beneficiary’s actual out of pocket liability, minus the amount payable by Medicare, also minus amount payable by other third party payers, subject to the limit under paragraph (d)(1)(ii) of this section.

(B) For items or services or segments of items or services for which no payment may be made under Medicare, the CHAMPUS payment will be the same as it would be for a CHAMPUS eligible retiree, dependent, or survivor beneficiary who is not Medicare eligible.

(iv) *Examples of applications of general rule.* The following examples are illustrative. They are not all-inclusive.

(A) In the case of a Medicare-eligible beneficiary receiving typical physician office visit services, Medicare payment generally will be made. CHAMPUS payment will be determined consistent with paragraph (d)(1)(iii)(A) of this section.

(B) In the case of a Medicare-eligible beneficiary residing and receiving medical care overseas, Medicare payment generally may not be made. CHAMPUS payment will be determined consistent with paragraph (d)(1)(iii)(B) of this section.

(C) In the case of a Medicare-eligible beneficiary receiving skilled nursing facility services a portion of which is payable by Medicare (such as during the first 100 days) and a portion of which is not payable by Medicare (such as after 100 days), CHAMPUS payment for the first portion will be determined consistent with paragraph (d)(1)(iii)(A) of this section and for the second portion consistent with paragraph (d)(1)(iii)(B) of this section.

(v) *Application of catastrophic cap.* Only in cases in which CHAMPUS payment is determined consistent with paragraph (d)(1)(iii)(B) of this section, actual beneficiary out of pocket liability remaining after CHAMPUS payments will be counted for purposes of the annual catastrophic loss protection, set forth under Sec. 199.4(f)(10). When a family has met the cap, CHAMPUS will pay allowable amounts for remaining covered services through the end of that fiscal year.

(vi) *Effect of enrollment in Medicare+Choice plan.* In the case of a beneficiary enrolled in a Medicare+Choice plan who receives items or services for which payment may be made under both the Medicare+Choice plan and CHAMPUS, a claim for the beneficiary's normal out-of-pocket costs under the Medicare+Choice plan may be sub-

mitted for CHAMPUS payment. However, consistent with paragraph (c)(4) of this section, out-of-pocket costs do not include costs associated with unauthorized out-of-system care or care otherwise obtained under circumstances that result in a denial or limitation of coverage for care that would have been covered or fully covered had the beneficiary met applicable requirements and procedures. In such cases, the CHAMPUS amount payable is limited to the amount that would have been paid if the beneficiary had received care covered by the Medicare+Choice plan.

(vii) *Effect of other double coverage plans, including medigap plans.* CHAMPUS is second payer to other third-party payers of health insurance, including Medicare supplemental plans.

(viii) *Effect of employer-provided insurance.* In the case of individuals with health insurance due to their current employment status, the employer insurance plan shall be first payer, Medicare shall be the second payer, and CHAMPUS shall be the tertiary payer.

(2) *CHAMPUS and Medicaid.* Medicaid is not a double coverage plan. In any double coverage situation involving Medicaid, CHAMPUS is always the primary payer.

(3) *TRICARE and Workers' Compensation.* TRICARE benefits are not payable for a work-related illness or injury that is covered under a workers' compensation program. Pursuant to paragraph (c)(2) of this section, however, the Director, TRICARE Management Activity, or a designee, may authorize payment of a claim involving a work-related illness or injury covered under a workers' compensation program in advance of adjudication and payment of the workers' compensation claim and then recover, under §199.12, the TRICARE costs of health care incurred on behalf of the covered beneficiary.

(4) *Extended Care Health Option (ECHO).* For those services or supplies that require use of public facilities, an ECHO eligible beneficiary (or sponsor or guardian acting on behalf of the beneficiary) does not have the option of waiving the full use of public facilities which are determined by the Director, TRICARE Management Activity or

designee to be available and adequate to meet a disability related need for which an ECHO benefit was requested. Benefits eligible for payment under a state plan for medical assistance under Title XIX of the Social Security Act (Medicaid) are never considered to be available in the adjudication of ECHO benefits.

(5) *Primary payer.* The requirements of paragraph (d)(4) of this section notwithstanding, TRICARE is primary payer for services and items that are provided in accordance with the Individualized Family Service Plan as required by Part C of the Individuals with Disabilities Education Act and that are medically or psychologically necessary and otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option.

(e) *Implementing instructions.* The Director, OCHAMPUS, or a designee, shall issue such instructions, procedures, or guidelines, as necessary, to implement the intent of this section.

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§ 199.9 Administrative remedies for fraud, abuse, and conflict of interest.

(a) *General.* (1) This section sets forth provisions for invoking administrative remedies under CHAMPUS in situations involving fraud, abuse, or conflict of interest. The remedies impact institutional providers, professional providers, and beneficiaries (including parents, guardians, or other representatives of beneficiaries), and cover situations involving criminal fraud, civil fraud, administrative determinations of conflicts of interest or dual compensation, and administrative determinations of fraud or abuse. The administrative actions, remedies, and procedures may differ based upon whether the initial findings were made by a court of law, another agency, or the Director, OCHAMPUS (or designee).

(2) This section also sets forth provisions for invoking administrative remedies in situations requiring adminis-

trative action to enforce provisions of law, regulation, and policy in the administration of CHAMPUS and to ensure quality of care for CHAMPUS beneficiaries. Examples of such situations may include a case in which it is discovered that a provider fails to meet requirements under this part to be an authorized CHAMPUS provider; a case in which the provider ceases to be qualified as a CHAMPUS provider because of suspension or revocation of the provider's license by a local licensing authority; or a case in which a provider meets the minimum requirements under this part but, nonetheless, it is determined that it is in the best interest of the CHAMPUS or CHAMPUS beneficiaries that the provider should not be an authorized CHAMPUS provider.

(3) The administrative remedies set forth in this section are in addition to, and not in lieu of, any other remedies or sanctions authorized by law or regulation. For example, administrative action under this section may be taken in a particular case even if the same case will be or has been processed under the administrative procedures established by the Department of Defense to implement the Program Fraud Civil Remedies Act.

(4) Providers seeking payment from the Federal Government through programs such as CHAMPUS have a duty to familiarize themselves with, and comply with, the program requirements.

(5) CHAMPUS contractors and peer review organizations have a responsibility to apply provisions of this regulation in the discharge of their duties, and to report all known situations involving fraud, abuse, or conflict of interest. Failure to report known situations involving fraud, abuse, or conflict of interest will result in the withholding of administrative payments or other contractual remedies as determined by the Director, OCHAMPUS, or a designee.

(b) *Abuse.* The term "abuse" generally describes incidents and practices which may directly or indirectly cause financial loss to the Government under CHAMPUS or to CHAMPUS beneficiaries. For the definition of abuse, see § 199.2 of this part. The type of